Family Model Residential Support Protocol Checklist

Service Recipient's Name _____ **Date of Birth** _____
(Last, First)

Reviewer's Name _____ **Date Request Submitted** _____
(Last, First)

Technical Review

☐ **YES** ☐ **NO**	Is the correct funding source, site code, and service code used in Section C of the Individual Support Plan? If **YES**, continue to Question #1 in Section A or B as applicable. If **NO** and the wrong funding source, site code and service code is due to a simple error, correct the error and continue to Question #1 in Section A or B as applicable. If **NO** based on lack of a site code because the provider is not licensed or does not have an approved provider agreement, deny as non-covered due to failure to meet provider qualifications as specified in the waivers and in the TennCare rules applicable to the waivers.

A. Initial Request for Family Model Residential Support

1. ☐ **YES** ☐ **NO**	Is the request for Family Model Support to be provided in the home of the service recipient's family of origin? (A. 1.) If the answer is **YES**, deny as **non-covered service** based upon the waiver service definition. If the answer is **NO**, proceed to Question #2. (A.1.)
2. ☐ **YES** ☐ **NO**	Medically necessity review questions. a. Is there sufficient information in the Individual Support Plan (ISP) to justify that the service recipient needs direct support services due to: (A. 2. a.) (1) The service recipient's need for assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, and eating), instrumental activities of daily living (e.g., meal preparation, household chores, budget management, and attending appointments) and/or interpersonal and social skills building that will enable the service recipient to acquire, retain, or improve skills necessary to live in a home in the community; **OR** (A. 2. a. (1)) (2) A pattern of behavior by the service recipient that would pose a danger of harm to self or others; **AND** (A. 2. a. (2)) b. Is there sufficient information in the ISP and/or supporting documentation to show that *at least* one of the following is applicable: (A. 2. b.)

(1) The service recipient's need for direct support services and other services can **not** be safely and effectively met in the home for one of the following reasons :(A. 2. b. (1))

(a) The service recipient resides in a home with family members and: (A. 2. b. (1) (a))

i. The caregiver(s) died; **OR** (A. 2. b. (1) (a) i)

ii. The care giver(s) became physically or mentally incapacitated and can no longer reasonably provide caregiver services; **OR** (A. 2. b. (1) (a) ii)

iii. It is unsafe for the service recipient to remain in the home due to abuse or neglect by the caregiver(s) or by other individuals residing in the home; **OR** (A. 2. b. (1) (a) iii)

iv. The service recipient has a history of aggressive or abusive behavior toward the caregiver(s) or other individuals residing in the home, and the service recipient's continued presence in the home would present an imminent danger of harm to others in the home; **OR** (A. 2. b. (1) (a) iv)

(b) The service recipient resides in a home with individuals other than family members, **AND**: (A. 2. b. (1) (b))

i. The caregiver(s) are no longer willing or able to provide caregiver services; **OR** (A. 2. b. (1) (b) i)

ii. It is unsafe for the service recipient to remain in the home due to abuse or neglect by the caregiver(s) or by other individuals residing in the home; **OR** (A. 2. b. (1) (b) ii)

iii The service recipient has a history of aggressive or abusive behavior toward the caregiver(s) or other individuals residing in the home and the service recipient's continued presence in the home would present an imminent danger of harm to others in the home; **OR** (A. 2. b. (1) (b) iii)

(c) The service recipient is currently homeless , will be homeless within 30 days due to an eviction , or is being discharged from a hospital or other institution or custody of the Department of Children's Services and the service recipient does not have family members or others who are willing or able to provide a place of residence; **OR** (A. 2. b. (1) (c))

(2) It is more cost effective to meet the service recipient's needs for direct support services and other services through Family Model Residential Support rather than through the provision of other waiver services in the service recipient's home or in a home with family members or other caregivers. (A. 2. b. (2))

If **YES to both** criteria specified in "2.a" through "2.b" above, proceed to question #3.

If **NO to any** criterion specified in "2.a" through "2.b" above, stop and deny as **not**

	medically necessary.
3. ☐ **YES** ☐ **NO**	Is the service recipient age 18 or older? (A. 3.) If **YES**, stop and approve the Family Model Residential Support (A. 3.) If **NO,** proceed to Question # 4. (A. 3.)
4. ☐ **YES** ☐ **NO**	Can the service recipient's needs be appropriately met though waiver and other services provided in the home where the service recipient resides with family? (A. 4.) NOTE: Except under ***exceptional circumstances***, Family Model Residential Support will not be provided for a service recipient under the age of 18 if waiver and other services can be provided to appropriately maintain the service recipient in the home where the service recipient resides with family. Any request for exception must be submitted *in writing* to the DMRS Central Office and must specify the service recipient's medical conditions, diagnoses, and/or disabilities that create the need for Family Model Residential Support and must provide documentation specifying why the service recipient's needs can not be met in the home where the service recipient resides with family. If **YES**, stop and deny Family Model Residential Support as **not medically necessary.** If **NO,** stop and approve Family Model Residential Support. (A. 4.)
☐ **Approved**	
☐ **Denied**	

B. Continuation of Family Model Residential Support

1. ☐ **YES** ☐ **NO**	Is the request for Family Model Support to be provided in the home of the service recipient's family of origin? (B. 1.) If **YES**, deny as **non-covered** based upon the waiver service definition. If **NO**, continue to Question #2.
2. ☐ **YES** ☐ **NO**	Medical necessity review questions. a. Is there significant information in the ISP to document that that the service recipient continues to need direct support services due to (1) The service recipient's need for assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, and eating), instrumental activities of daily living (e.g., meal preparation, household chores, budget management, and attending appointments) and/or interpersonal and social skills building that will enable the service recipient to acquire, retain, or improve skills necessary to live in a home in the community; **OR** (B. 2. a. (1)) (2) A pattern of behavior by the service recipient that would pose a danger of harm to self or others; (B. 2. a. (2)) If **YES,** stop and approve the continuation of the Family Model Residential Support.

	If **NO,** stop and deny as **not medically necessary.**
☐ **Approved**	
☐ **Denied**	